CLAIM FORM

Dependent Care Flexible Spending Account

Your Employer's Name: _____

EMPLOYEE Social Security Number: _____

EMPLOYEE Name:_____

Street Address/PO Box: _____

City: _____ State: _____ Zip: _____

Date of Claim(s): _____ Amount of claim(s): _____
*****List all dates or date range*** ***List total amount of all claims*******

Please Note:

Receipts from the day care provider must be attached for reimbursement. Canceled checks will NOT qualify.

Please send to: **Eagles, Benefits By Design (Eagles)**
2336 SE Ocean Blvd., Suite 301
Stuart, FL 34996
Fax 1-772-334-7059

If you have questions, please call 1-800-726-5603.

PLEASE NOTE: All claims for the plan year must be filed within 90 days after the plan year ends.

Signature: _____ Date: _____